2012-13 Annual Plan

Western Sydney Medicare Local

www.wentwest.com.au

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7101
F: (02) 9622 3448
ACN 099 255 106 / ABN 80 099 255 106

Table of Contents

Checklist and Attachments ..... **Error! Bookmark not defined.**

Annual Plan Checklist ..... **Error! Bookmark not defined.**

Attachments ..... **Error! Bookmark not defined.**

1 Organisational overview 3

1.1 Medicare Local contact information 3
1.2 Medicare Local region characteristics 4
1.3 Organisational structure and internal governance 9
1.4 Board membership 12
1.5 Company membership 13
1.6 Company objects 14
1.7 Key stakeholder relationships 15
1.8 Subcontractors ..... **Error! Bookmark not defined.**
1.9 List of attachments ..... **Error! Bookmark not defined.**

2 Medicare Locals Core Funding Program ..... **Error! Bookmark not defined.**

2.1 Key activities 22

2.2 Transition arrangements ..... **Error! Bookmark not defined.**

3 Medicare Local After Hours Program ..... **Error! Bookmark not defined.**

3.1 Key activities ..... **Error! Bookmark not defined.**

1 Organisational overview

*1.1 Medicare **Local contact information***

Medicare Local name:	Western Sydney Medicare Local
Medicare Local legal name (if different):	WentWest Limited
ABN:	80 099 255 106
Postal address:	PO Box 5, Blacktown Post Shop, Blacktown NSW 2148
Street address:	Level 1, 85 Flushcombe Road, Blacktown NSW 2148
Phone:	(02) 8811 7100
Fax:	(02) 9622 3448
Email:	wentwest@wentwest.com.au
Website:	www.wentwest.com.au
Branch office information:	N/a
CEO	Walter Kmet CEO (Permanent) Tel (02) 8811 7162 walter.kmet@wentwest.com.au
Annual Plan contact:	Ian Corless Tel (02) 8811 7170 ian.corless@wentwest.com.au

1.2 Medicare Local region characteristics

Overview of the characteristics and health status of the population

The communities within the Western Sydney Medicare Local boundaries stretch from Auburn in the East to Blacktown in the West, and to the Hills in the North, covering an urban, outer urban and semi-rural population of approximately 820,000 people. The population in this region is as diverse as the geography, with foreign born populations of over 50% in some areas, from affluent suburbs to extreme pockets of social disadvantage, and home to the largest Indigenous community living in urban Australia, as well as a large population of refugees.

Not only is the population rapidly expanding and ageing, health status in the region is below Metropolitan Sydney and state-wide averages for New South Wales, with major areas of socioeconomic and health disadvantage and consequent high prevalence rates for chronic conditions, hospital admissions and avoidable mortality. The most socially disadvantaged areas are often also those with the highest prevalence of risk behaviours (particularly rates for physical inactivity, male smokers and overweight males and females), chronic diseases (especially circulatory, respiratory and musculoskeletal system diseases), and workforce issues.

Particular areas of concern regarding health and social disadvantage include Auburn, Blacktown Southwest (Mt Druitt and surrounds), and Parramatta South. **The most notable characteristics and health indicators within the region are:**

- **Our ageing population**: In Parramatta Northwest and Parramatta Northeast, people over 65 years make up 15.4% and 14.2% of the population respectively (*Medicare Local Health Profiles,* 2011). By 2020, this is expected to increase to 19.7% in Parramatta Northwest and 17.3% in Parramatta Northeast.[1] Region wide by 2020, people over 65 years are expected to increase from 9.9% of the population to 12.5%.

- **Our multicultural community**: Our population demonstrates incredible diversity with large percentages of people born in predominantly non-English speaking

[1] PHIDU, *A Social Health Atlas of Australia,* 2011

countries. 50.2% of Auburn residents, 47.3% of Parramatta Inner residents, 38.3% of Parramatta South residents, and around one third of residents in Holroyd, Blacktown Southeast, and Parramatta Northeast are born in predominantly non-English speaking countries. This compares to 23.9% in Metropolitan Sydney and 13.8% Australia wide. 16% of people in Auburn and 10.8% in Parramatta South have poor English proficiency, compared to 4.7% in Metropolitan Sydney and 2.4% Australia wide. Over 4% of the population in Blacktown Southwest are Aboriginal or Torres Strait Islander, compared to around 1% in Metropolitan Sydney.

- **Our large refugee population**: 6 of the top 10 SLAs of refugee settlement in NSW fall within the Western Sydney boundaries. In the 10 years to October 2011, close to 16,000 people of refugee or humanitarian backgrounds have settled in Western Sydney.[2]

- **At-risk families, children and mothers**: Roughly a third of families with children under 15 in Parramatta South, and over a quarter in Blacktown Southwest and Auburn, are jobless. This compares to 14% in Metropolitan Sydney. 16.5% of families with children less than 15 years in Blacktown Southwest and 10.5% in Blacktown Southeast, are single parent families, compared to 7.8% in Metropolitan Sydney. In Blacktown Southwest, 8.6% of babies born have low birth-weight compared to 6.1% in Metropolitan Sydney, and nearly a quarter of all pregnant mothers smoke, compared to 8.8% in Metropolitan Sydney. Rates of domestic violence assaults for Blacktown are the highest in the region (579 per 100 000 people compared to 364 for Metropolitan Sydney) (NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics 2010*).

- **High Unemployment**: In many areas, unemployment is markedly higher than the average of 5.6% for Metropolitan Sydney, with rates of 9.9% in Auburn, 14.5% in Blacktown Southwest, and 11.9% in Parramatta South.

- **Mental health**: Residents of socially disadvantaged areas demonstrate elevated levels of psychological distress compared to Metropolitan Sydney. The standardised rate of high or very high levels of psychological distress is 143 in Parramatta South, 130 in Auburn, and 128 in Blacktown Southwest, compared to 102 in Metropolitan Sydney. The prevalence of mood (affective) disorders is also significantly higher in Blacktown Southwest and Parramatta South than

[2] Australian Government Department of Immigration and Citizenship, Settlement Reporting Facility, accessed at http://www.immi.gov.au/settlement/ on 9 November 2011.

Metropolitan Sydney averages.

- **High Avoidable Mortality** – Rates of avoidable mortality are markedly higher than Metropolitan Sydney averages in the areas of Blacktown Southwest, Blacktown Southeast and Parramatta Inner. These rates are disproportional when compared to chronic disease rates for the areas which are more or less equivalent to Metropolitan Sydney averages. This could be an indicator of poor performance of the health system in these areas.

- **Obesity and physical inactivity** – The region-wide rate of physical inactivity among people aged 15 and over is 37%, which is higher than the Metro Sydney average of 34%. In both Auburn and Parramatta South rates are alarmingly high at 46%. Rates of obesity in the region are 21.3% for males and 16.3% for females over 18, which are higher than Metro Sydney averages. Areas of concern are Blacktown Southwest, with a male obesity rate of 29.4% and a female obesity rate of 18.8%; Parramatta South, with a female obesity rate of 19.1% and Auburn with a male obesity rate of 26.7%.

- **More affluent, family based suburbs:** the SLAs of Baulkham Hills Central and Baulkham Hills North demonstrate much higher IRSD scores than the rest of Western Sydney, as well as low unemployment, better self reported health, lower levels of chronic disease and lower prevalence of health risk factors.

1.3 Strategic Direction

There has been clear focus and consistency in the strategic direction of WSML and the sections below are lifted from the 2011 ML Strategic Plan submission.

The success of the WSML will be driven by effective strategic planning, alignment of resources to areas of highest community need, development of organisational capability/capacity and strategic approaches to stakeholder engagement community engagement. There will be a number of key focus areas for the WSML with the following highlights:

1. **A collaborative partnership with Western Sydney Local Health District (WSLHD)** will be strengthened and built upon towards agreed areas of joint

priority and mutual benefit with the development of explicit plans to address these. The partnership will focus on the top key priority areas with collaboration at all levels from Board through senior management to program/clinical staff around patient care. In addition the WSML/LHD will where appropriate align effort and resources to reduce duplication and improve service delivery to the western Sydney Community, resulting in the provision of flexible services that respond to current and emerging community needs.

2. **Effective engagement with the many and varied stakeholders in the Western Sydney community and primary health care arena.**

   The WSML will develop a strong community forum that will allow primary health care issues to be discussed and better planned with input from the community. In addition, the development of our LGA- based Local Community Partnerships (LCPs) will be the vehicles by which we enlist a broad cross section of key individuals and groups in the primary health care field who will come together and be informed by evidence based population health needs, formulate appropriate local strategies and plans for action.

   Particular strengths will be:

   - Development and extension of innovative models of care grounded in and evolved from existing programmes such as HealthOne, Connecting Care/Severe Chronic Disease Management and Ante Natal Shared Care
   - Integration of After Hours provision within existing infrastructure
   - Our collaboration with the Aboriginal Medical Service
   - Community engagement

3. **Continued excellence in the delivery of support to general practitioners and expansion of support services to other allied health professionals**

   The WSML will provide high level quality support services to GPs and general practices, with a focus on continuous quality improvement. Support services will be expanded to include allied health professionals (AHPs). AHP needs will be identified to develop programs that support and assist in better patient management and to enhance practice management services.

Particular strengths will be:

- High level continuous quality improvement activities occurring in GP and PHC settings
- Development of models of care to support and enhance clinicians and service providers in provision of care for hard to manage population groups

4. **Build capability and capacity to undertake population health analysis to determine priority area of focus.**

   From the outset WSML will further evolve its ability to gather, integrate and leverage quality data to inform its activities from support of the LCPs and other programs to broader level planning with the LHD and other stakeholders.

   Particular strengths will be:

   - Partnerships to leverage multiple data sources
   - Utilisation of LHD population health planning capability via formal partnership and governance mechanisms
   - Ability to turn data into knowledge to assist effective prioritisation and planning
   - Evidence at the core of all programme and service development

5. **Enhance and capitalise on WentWest's position as the RTP (Regional Training Provider) for Western Sydney to build workforce capacity at a local and state level and broaden educational provision beyond the current GP focus to allied health professionals**

   Particular strengths will be:

   - Broad based educational initiatives across provider groups in WSML
   - Leverage RTP to improve workforce retention rates and bolster after hours provision capacity
   - A stronger relationship between the WSML, University Sydney, UWS, Education Teaching research Network.

6. **Build an agile, well governed and change responsive organisation that attracts, retains and develops the human resource capability to deliver on the broader ML objectives**

   Particular strengths will be:

   - Governance model and calibre of our skills-based board
   - Leadership quality across the organisation
   - Recognition as a learning organisation
   - Our community driven and needs responsive culture

7. **Develop the capability, capacity and functional alignment to deliver on our mission and the WSML strategic objectives**

   Particular strengths will be:

   - Efficient and effective functional alignment to deliver on the ML mission
   - Structure and resourcing informed by stakeholder need and strategic priorities
   - Systems installed and developed that seamless support the business

These areas of focus remain, but during the time since the submission of our Medicare Local Strategic Plan our thinking around effective plan execution has evolved based on ongoing stakeholder dialogue, emerging partnerships and greater understanding of community needs. This will be reflected in sections of this 2012-2013Annual Plan.

1.4 Organisational structure and internal governance

Board Structure and Membership

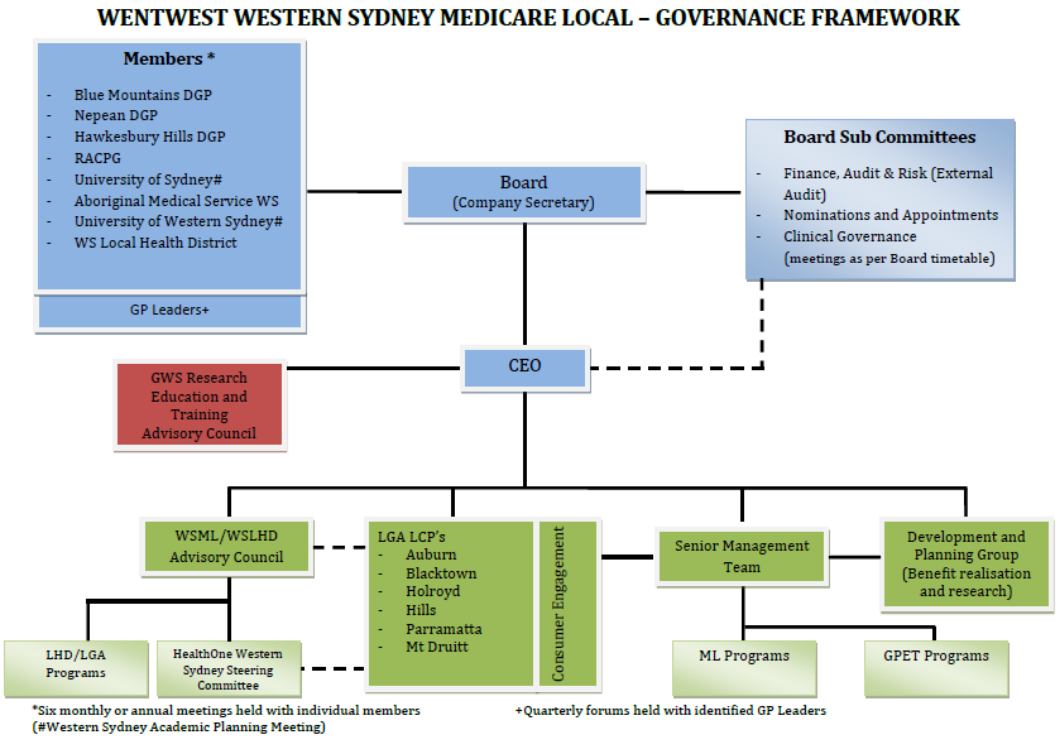
The Board structure has moved to a skills-based Board (from what was previously a representative Board where member organisations could nominate directors directly to the Board, to a solely skills-based Board in accordance with a skills matrix). This was completed in January 2012 as planned and now has a total current Board membership of seven.

Future Board membership will either be via election by the members in a general meeting in accordance with the appropriate clause in the constitution or appointed by the Board (or the sole Director) in accordance with the appropriate clause in the constitution.

Governance Framework

The governance framework has evolved since our last plan submission primarily to reflect the deepening and more formal partnership being forged with the LHD.

This is captured by the creation of the WSML/WSLHD Advisory Council with clear line of sight to and linkage with the broader governance framework.



Within the Medicare Local, the main functional groups are now aligned as outlined below with a member of the Senior Management Team leading each area

COMMUNITY PROGRAMS	PROGRAM INTEGRATION	BUSINESS PROGRAMS
• Community Programs and Engagement • Indigenous Programs • Marketing - Health Promotion • Communication and Media • Corporate Partnerships	• Local Community Partnership - Advisory Councils - Health and Population Planning • Clinical Governance Coordinators - Health One • LHD Partnership and Interface - Connecting Care - CHIP - Health Care Pathways • Community and Consumer Forum • Citizen Juries • Primary Health Care Networks	• Area Services Coordinators • NPS • Clinical Services - ATAPS • Quality and Practice Support - Consulting Services • After Hours Care • PCEHR/eHealth

Business Development and Planning Group

The attached organisation chart shows how this alignment is executed in terms of team and individual roles.

1.5 Board membership

Position on board	Name	Expertise	Current Profession	Date of Appointment
1. Chair	Diana O'Halloran	Health	Stakeholder engagement	Oct 2005
2. Deputy Chair	Tim Usherwood	Education, training & research; Health	Stakeholder engagement	Jan 2002
3. Director	Bradley Delaney		Community & stakeholder engagement	Aug 2011
4. Director	Linda McQueen	General Practice; Corporate governance		Dec 2008
5. Director	Michael Tan	General Practice; Education, training & research		Apr 2007
6. Director	Carolyn Lamb	Corporate governance; law	Community & stakeholder engagement	Jan 2012
7. Director	Alan Zammit	Corporate governance; finance	Community & stakeholder engagement	Jan 2012
8. Company Secretary	Lesley Brookes	Company Secretary		Mar 2012

Transitional arrangements for Board appointments

Now completed

1.6 Company membership

Membership structure

Under WentWest Limited's Constitution (2011) there is one class of membership. The membership of the company currently consists of the five organisations which held membership at the time of the adoption of the Constitution. Under the Constitution other organisations can be admitted to membership of the company.

Since the adoption of the Constitution in late 2011 WentWest has invited a number of organisations to make application for membership of WentWest, and received a number of membership enquiries, including from peak bodies, and individuals on behalf of allied health professionals and other health providers.

In April 2012 the Board of WentWest adopted a policy on assessing membership applications, and plans to process all applications received at subsequent Board meetings, ensuring that all membership is conferred in time for the 2012 AGM.

Under Clause 10.18 of the Constitution nominations of directors can submitted by members, Associates (who are not members) or Advisory Committees.

Category	Number of Organisational Members	Number of Individual Members
Medical		
General Practice	3	
Peak organisations		
Royal Australian College of General Practice	1	
Education, training and research		
Universities	2	
Aboriginal Medical Service	1	
Western Sydney Local Health District	1	

Company objects

Extract from Clause 2 of the WentWest Limited Constitution 2011:

The ultimate objects of the Company are to improve the health of the local community through, amongst other things:

- leading and delivering high quality general practice and primary health care education, training and support to benefit patients, communities, general practice and primary health care providers, and to develop a sustainable high quality primary health care workforce;
- encouraging, supporting and working collaboratively to achieve improvements in the delivery of integrated, accessible, equitable, high quality primary health care services to patients, including initiatives aimed toward improving disease prevention and management, raising patient awareness and capability, and improving access to appropriate services;
- improving the planning of primary health care services to identify the community's health needs, to develop locally focussed and responsive health services, and to address service delivery gaps;
- promoting primary care and the centrality of general practice and primary health care in the delivery of effective integrated health service management for the local community;
- providing support to clinicians and health service providers to augment the quality of their patient care, their professional satisfaction, and ability to function as effective teams;
- promoting a culture of efficiency, accountability and continuous improvement in the delivery of primary health care services.

1.7 Key stakeholder relationships

Patients and consumers (including Aboriginal and Torres Strait Islander representatives)

- WSML will reconvene its established Consumer and Community Forum to assist with priority and plan reviews for each Local Community Partnership as these are agreed;
- WSML has agreed access to consumer panels with a number of local councils and these will be utilised through the plan period to seek additional consumer input and guidance as needed;
- WSML will execute a number of Citizens Juries' during the course of the Plan to further gather consumer input in relation to our work and progress.

Clinicians, health services providers and their representative bodies (across the spectrum of primary care, and where relevant secondary and acute care, and Aboriginal and Torres Strait Islander representatives)

- The six Local Community Partnerships will continue and evolve both as the prime vehicle for local (LGA) focussed provider engagement, but also as the lynchpin of the LHD/ML partnership. The use of the PLATFORMS SERVICE REDEVELOPMENT FRAMEWORK will ensure comprehensive representation and input;
- Extensive one-on-one consultation with key stakeholders in each LGA including clinicians, AHPs and other service providers will continue;
- Review of online and other communications channels underway with routine updates and newsletters produced to directly target identified key stakeholder groups;
- Extensive Allied Health Professional engagement will continue with creation of an AHP advisory panel and an annual AHP needs and satisfaction survey;
- WentWest will work with General Practice Accreditation bodies such as AGPAL and GPA Plus to promote the uptake of accreditation status and support practices through the process.

Local Hospital Networks

WSML has finalised a Partnership Memorandum with the Western Sydney Local Health District (the only LHN in our area) with the following purpose and principles and this will form the basis of our future collaboration:

Purpose

The parties agree to work together to establish a Partnership to ensure formal mechanisms for consultation and collaboration between the parties, including opportunities within the Shared Geographical Boundaries to address the Common Health Priorities and engage in and support each other's programs, projects and committees including through the following initiatives:

- WSLHD to contribute towards and assist WSML in meeting its obligations in connection with WSML's DoHA approved strategic plan and the Commonwealth Medicare Local Strategic Objectives;

- WSML to contribute towards and assist WSLHD meeting its obligations in connection with WSLHD's strategic plan and the NSW Health State Plan Strategic Direction; and

  the parties together will:

  - develop strategies for collaborating to address the Common Health Priorities;
  - develop programs to promote health and reduce chronic disease;
  - develop and influence an integrated approach in the provision of primary health care and acute hospital based care and the interface with other entities in delivery of health care to members of the public;
  - engage patients, carers and consumers in designing models of care and monitoring outcome of health care services;
  - identify and address health needs of all members of the public on an equitable and ongoing basis with a particular focus on Aboriginal communities and culturally and linguistically diverse communities;

- identify and deliver the best achievable health services attainable from available resources and to cooperate in seeking additional resources as required, having regard to identified priorities;
- support agreed research and development projects;
- actively seek opportunities to share expertise in clinical governance and best practice in clinical care; and
- participate in training and development initiatives and workforce and infrastructure development.

Key Principles of Collaboration

The parties acknowledge the following statement of principles apply to their collaboration under this memorandum and any progress to formal agreements in connection with this memorandum:

- service planning and delivery will seek to be person centred;
- the capacity to improve health and wellness will be enhanced by strong partnerships and collaborations across health and human service systems which are sometimes multi -jurisdictional;
- teamwork and local community engagement will support integration of services and continuity of care;
- equity and access to services will be improved by identifying and prioritising individual and community needs so that services can be provided at the right place and at the right time;
- the parties will demonstrate, through their responsive and timely action, a willingness to make the collaboration succeed;
- the parties share a common vision, values, and understanding of the scope of their individual obligations under the memorandum;
- the parties recognise that improving quality and safety of health care and system change will take time and can be assisted greatly by well structured collaboration, teaching and research;
- integration initiatives will be delivered in a secure environment with acceptable levels of privacy and confidentiality protection; and

- each party will actively seek to leverage off the other's core capabilities, especially in areas such as clinical governance and practice where there are not only mutual benefits of that collaboration but also shared responsibilities across acute and primary care settings.

Local Lead Clinician Groups (once established)

- In the absence of the local lead clinicians groups, WSML will effectively engage with lead clinicians via the joint working groups established between the WSLHD and WSML focussing on agreed health priorities. These incorporate strong lead clinician representation.

- WSML will build on existing relationships with local General Practitioner associations such as the Mount Druitt Medical Association and Blacktown Medical Practitioner Association by providing a capacity building grant and support their Continuous Professional Development activities by providing event planning and management support.

- WSML will explore the establishment of other Local GP networking groups by providing a set up grant to build local GP networks in the remaining 4 LGAs. These groups will provide GP networking and CPD support.

Community Organisations

- WSML will continue to build on its database of over 130 different community groups and organisations and will ensure routine communications are generated via print media and digital formats as well as face to face meetings.

- WSML will continue to partner with local health promotion and exercise services to increase the uptake of exercise routines in the local community. This includes working with local sporting and recreation clubs to provide subsidised exercise services for high-risk and vulnerable population groups including those from CALD and ATSI backgrounds, seniors children and families, low income earners, and the overweight/obese. Additional organisations include:

  - Embark Cottage;

- Newpin;
- Cultural Society Bosnia Herzegovnia NSW;
- Breast Cancer Institute;
- Headspace;
- Chifley Senior College;
- Auburn Diversity Services;
- Mt Druitt Community Health
- WASH House
- Blacktown Mental Health Unit

State/Territory Government

- WSML will continue to keep NSW Health informed of ML progress- ongoing correspondence and collaboration with local MPs Michelle Rowland, Ed Husic, Julie Owen and joint planning via WSLHD. Where possible the organisation will work with local MPs on joint promotional opportunities in launching key aspects of WSML activities and milestones (e.g. PCEHR rollout)
- Advocate for local initiatives/change via government channels- various- position papers and briefs to senior officials within NSWH.

Researchers and Educators

- Key Stakeholders have been informed on Teaching and Research advancements through face to face meetings and Weekly updates distributed by WSML.
- The Western Sydney Academic Primary Care Committee is continuing and is enhanced by the strength of our long standing relationships with the Universities.
- Through the Education Integration Project, a partnership with WentWest, USyd and UWS, five cluster areas are being developed to foster vertical integration of teaching for Medical Students, GP Registrars

and Prevocational Doctors undertaking GP Rotations in our region. It is planned that the cluster areas will look at multidisciplinary teaching as well as research within General Practice.

- GP registrars and PGPPP doctors regularly attend WSML education sessions and workshop and are supported in practice through the WSML practice support team. WSML will continue to promote research opportunities to General Practitioners and Practice Nurses and expand promotion to Allied Health Care Professionals.

- WSML will continue to partner with Practice Nurse Clinical Education providers to provide sponsored CNE opportunities. Organisations include Family Planning NSW, The College of Nursing, Benchmarque and The Australian Lung Foundation.

- WSML will continue to partner with Business Education providers to provide sponsored CPD opportunities to Practice Managers and Reception staff. Organisations include Australian Practice Managers Association, TAFE NSW and UNE.

Media

- Communications Plan developed and being actioned to keep identified stakeholder groups informed and engaged with WSML's progress and performance in meeting key milestones;

- Key local media outlets identified, contacted on an ongoing basis and press releases and possible stories forwarded as the opportunity arises.

Staff

- Routine monthly staff meetings undertaken to brief internal staff on progress with our ML work.

- Results of an exhaustive internal communication audit will be used to ensure information is provide to staff in a timely manner in the format and by the channel they prefer.

- Work is underway to build more effective cross-functional collaboration and communication, an increasingly critical requirement as the ML increases in complexity, scope and size.

Other Key Stakeholders

- WentWest will continue to partner with the Heart Foundation on preventative and health promotion activities in general practice. The Prevention in Primary Health Care Project focused on increasing referrals into local referral services for SNAPO (Smoking, Nutrition, Alcohol, Physical Exercise and Obesity) will continue with WentWest provided the project plan for 2012-2015 is approved by the funding body;
- WSML will continue to work in partnership with the Aboriginal Medical Service and other community organisations across the region to identify the health needs, gaps and planned response to address local Aboriginal health issues.

1.8 Key activities

Strategic Objective 1. Improving the patient journey through developing integrated and coordinated services

1.1 **Community Programmes**

Work with the AMSWS and key stakeholders to progress Aboriginal and Torres Strait Islander Primary Health Care Education and Support:

1.1.1 Provide and promote current available Aboriginal and Torres Strait Islander educational materials, programs and initiatives to targeted groups and their health care providers

1.1.2 Evolve educational materials, services, programs and initiatives in conjunction with key stakeholders including AMSWS and based on emerging needs

Planning:

1.1.3 Develop an Aboriginal Primary Health Care reference group in partnership with the AMSWS and WSLHD Aboriginal Health Unit to identify and address health needs and gaps for the local Aboriginal community.

1.1.4 Scoping of gaps in service for Aboriginal Patients with development of plan to fill these gaps

Mental Health:

1.1.5 Continue to provide Aboriginal specific ATAPS program to target Aboriginal and Torres Strait Islander people whom are suffering from grief and loss and require ongoing assistance and support.

Practical Assistance – Service Coordination:

1.1.6 Continue to link identified patients into existing processes developed to support continued care across care providers by addressing psycho-social needs. This will be facilitated through WSML Aboriginal Outreach Workers who assist with:

- Patient identification
- Health care provider support
- Intensive ongoing patient support through liaison with GPs and community nurses

- Transport linkage
- Linkage to other relevant services to address patients holistic needs

Care Coordination & Supplementary Services:

1.1.7 Deploy clinical care coordination nurses to receive referrals, enroll patients, and provide intensive clinical support and care coordination

1.1.8 Coordinate the receipt of applications for supplementary services funds to support identified patients in accessing additional relevant allied health services

1.1.9 Increase the uptake of MBS item 715 the Aboriginal Health Assessments; provide GPs/Practices with support through targeted Aboriginal Health Check clinics led by WentWest Care Coordinators (qualified Nurses) and the Aboriginal Outreach Worker (completing their AHW Cert. IV clinical Stream).

1.1.10 Provide Diabetes Support Clinic to Aboriginal and Torres Strait Islander patient through WSML SHAPE program.

1.1.11 Provide Educational workshop targeting those Aboriginal and Torres Strait Islander patients to increase their awareness in regards to their chronic conditions, the workshops will be provided out in the community for Aboriginal and Torres Strait Islander people to access and learn about such subject for E.g. Kidney Disease

1.1.12 GP Support in the effective management of ATSI patients

1.1.13 Care Support in the effective and holistic management of ATSI patients and their health care needs.

Objectives for the Aboriginal and Torres Strait Islander population for the Hills region will be met through either direct service transfer and delivery of agreed items by WSML, the WSML CTG team will develop referral pathways through several key stakeholders in the Hills district working with GPs/practices to ensure they are aware of the services that the WSML provide for Aboriginal and Torres Strait Islander patients through the Close the Gap program.

Engage other key stakeholders in areas such as local community centres, Schools and other organisations that engage with the local Aboriginal and Torres Strait Islander population will also be engaged to access the WSML CTG program to ensure those Aboriginal and Torres Strait Islander people are aware of the Close the Gap measures and how to access these services.

Develop and implement a series of relevant and effective marketing campaigns to support the awareness and adoption of services for targeted patients groups.

1.1.14 **Web:** Establishment of a Web and Social Media Strategy to enhance the awareness and adoption of services through online channels, including website redevelopment and leveraging of social marketing and online advertising in the execution of specific campaigns;

1.1.15 **Style Guide:** Implementation of WSML branding across service lines in addition to the further development of a strategy to support the evolution of sub-brands such as After-Hours, PCEHR, Mental Health, Practice Support, Local Community Partnerships, SHAPE Health and Fitness and Close the Gap;

1.1.16 **Communications:** Development and implementation of a WSML Communications and Engagement Strategy which appropriately and regularly informs identified stakeholder on WMSL milestones, activities and opportunities for consultation.

1.1.17 **Media:** Development of a Media and Public Relations Strategy which builds the profile of WSMLs work within the local community through various media channels. Including the leveraging of public health days (such as Diabetes Awareness Week, Healthy Weight Week, and Naidoc) to promote good news stories;

1.1.18 **Advertising and Promotions:** Development of an overarching strategy to support the rollout of key programs/service lines in reaching targeted population groups. Including but not limited to direct mail campaigns, promotional events and advertising in a range of print, online and outdoor media;

1.1.19 **Workforce Development:** Implement an internal communications strategy which aims to develop a consistent and relevant voice on WSML activities for targeted audiences and stakeholder groups;

1.1.20 **Customer Relationship Management:** Work with key business units to develop and implement a CRM system which reflects the evolving needs of our diverse audiences, including the ongoing management and coordination of relationships with key stakeholders on WSML activities; and

1.1.21 **Sponsorship:** Develop a sponsorship strategy which can provide WSML with the opportunity to penetrate identified population groups through targeted support and partnership of local community organisations.

1.2 Program Integration

1.2.1 MoU with the LHD - formalising the partnership between the Medicare Local and the LHD to facilitate information sharing, collaboration and consultation. The partnership will consult and collaborate to address common health priorities and engage in and support each other's programs, projects and committees.

DRAFT WSML - WSLHD Partnership Framework

Commonwealth Medicare Local Strategic Objectives

NSW Health & State Plan Priorities

WSML Deliverables

WSLHD Deliverables

Partnership Deliverables

WSML - WSLHD Partnership Agreement

WSML LCP Advisory Council

Planning at LHD Level

WSML
- Population health planning
- Care pathways
- Service mapping
- Community and consumer consultation

Partnership Principles
- Clear communication & decision making processes
- Clear roles/ responsibilities

WSLHD
- Chief Executive Performance Agreement KPIs
- Implementation of targeted population strategies
- Implementation of Policy Directives,
  Models of Care e.g.
  - Aged Care
  - Mental Health
  - Chronic Disease Management
  - etc

Planning at LGA Level

Local Community Partnerships
- LGA level
- Identification of population health needs
- Population health planning
- Service mapping
- Gap analysis
- Stakeholder engagement
- Community and consumer consultation

Partnership Principles
- Sharing information & data
- Clear roles/responsibilities
- Joint Planning
- Access to expertise

Communicating/Facilitating Integration Coordination and Locality Level Partnerships

Facilitation of Service Integration
- Locality level planning
- Facilitating communication
- Facilitating partnerships and collaboration
- Leadership
- Facilitation of strategic and tactical outcomes for health priorities
- Advocacy

Partnership Principles
- Locality level linkages
- Agreed process for joint planning
- Strategic linkages with LCP planning process
- Participation in LCP
- Consumer and locality consultation

Locality Level
- Clinical redesign
- Service and system change management
- Processes which improve coordination of care
- Service provision planning and coordination

Service Delivery

Service Delivery Level
- Liaison and negotiation with service deliverers e.g. WSLHD, GPs
- Fund holder
- Facilitate new business models, brokerage, tenders
- Influence service delivery mechanisms

Partnership Principles
- Joint planning for integrated care delivery and service collaboration
- Explore new Models of Care to

Service Delivery Level
- Processes which improve coordination of care
- Integrated primary health care models
- Core Service provision

HealthOne
- Enrolment based model for agreed target groups
- Community based primary health care providers and GPs
- Integrated service delivery

1.2.2 Evidence based planning through completion of a comprehensive population health needs assessment to guide and support population health based planning and workforce capacity and development.

1.2.3 Integration and coordination of primary health care services - we will build upon and develop existing integration programs including Connecting Care, HealthOne, Antenatal Shared Care, Close The Gap and SHAPE. Further integration activities will be progressed utilizing a Local Community Partnership framework in each LGA to address population health needs at a local level.

1.2.4 LCPs will employ a population health approach to identify and develop strategies and activities to address local issues within these communities. The LCPs will operate at two levels:

- Level 1 - High level, strategic stakeholder engagement and priority health care planning encompassing direct health service delivery and those services that address the social, health and welfare issues impacting communities across Western Sydney

- Level 2 - Community and consumer stakeholder engagement at an operational level to guide the implementation of localized, integrated service delivery within each LGA

1.2.5 Connecting Care - The program in 2012-2013 to work with GPs and relevant service providers to improve the care planning and coordination for patients who frequently present to their Emergency Department to reduce avoidable admissions and improve patient outcomes. This program will be expanded with additional workforce and increased promotion with the expectation that the program will target a higher proportion of clients.

1.2.6 HealthOne facilitates the formation and implementation of service provider partnerships to address identified local health needs of Community Health clients. HealthOne GP Liaison Nurses assist with the identification and management of Child & Family Health and Chronic, Aged and Complex Care clients ensuring clients have a regular family doctor, a shared care plan with input from all providers involved in their care and regular communication and review with all services. Two facilities currently exist in Western Sydney and will be expanded to accommodate an additional four programs with

increased program support provided by the ML to promote and engage primary health care services.

ANSC will be reviewed to strengthen the existing model of care and explore opportunities to identify population health needs within the program and how services can work more effectively together to address these needs.

1.3 Business Programmes:

Practice Support: The team will assist with the realization of the strategic objective by:

1.3.1 Contributing to the mapping of the patient journey through the work of the Integration team and Local Community Partnerships team by assisting with data collection from general practices and allied health care professionals.

1.3.2 Measure capacity and demand, waiting times and patient satisfaction rates to address business systems with the intention of reducing patient waiting times.

1.3.3 Utilise information from the patient journey to inform primary health care staff of the issues and address service level barriers.

1.3.4 Liaise with existing primary health care stakeholders and leverage on strong relationships to engage in the collection of information and participation of initiatives aimed at improving the patient journey through integration and coordination.

1.3.5 Expand General Practice relationships to meet the broader Medicare Local mandate of service coordination to include the Local Health District, Allied Health Care Professionals, community health, aged care services, community organizations and local councils.

1.3.6 Collect patient access levels to Allied Health Services, Community health and specialist use.

Quality Improvement:

1.3.7 Collecting and analysing data will be a central function to quality improvement in health services within WentWest. Data collected will enable the accurate identification of problems, assists in prioritising quality improvement initiatives and enable assessment of improvement outcomes in each local area.

1.3.8 Quality improvement in WentWest is a system by which better health outcomes are achieved through analysing and improving service

delivery processes. Quality is defined as the 'extent to which a health care service or product produces a desired outcome'.

1.3.9 WentWest will work with health services to assist them with collecting and analyzing their own data across various quality domains so that problems areclear and self-evident triggering the health service to introduce appropriate improvements e.g. adverse events, infection rates and a range of other clinical indicators.

1.3.10 Collected data will help health services to understand and improve current service by giving them the tools to describe what is currently happening and to compare own performance, either against known standards, previous performance and national benchmarks.

e-Health Plan:

1.3.11 Further extend on the achievements of the Wave 2 PCEHR site outcomes, by registering 50 practices and up to 10,500 patients into the National PCEHR by the end of 2012. This body of work comes as a result of a Wave 3 transition project offer from NeHTA that will begin the implementation and adoption works to the national system.

1.3.12 Partner with six Medicare Offices in our region to support the enhance patient ability to register for the PCEHR

1.3.13 Continue to work on expanding and enhancing the WSML website to facilitate ease of navigation by the increased range of stakeholders.

1.3.14 As part of the WSML website upgrade, develop a comprehensive web-based service directory for all local primary health care clinicians to support holistic, person-centred care.

1.3.15 Work with the National Health Service Directory (NHSD) provider to list local services.

1.3.16 Scope the creation of a conformant local repository and associated software. This will link local services and allow the secure exchange and warehousing of clinical information in many forms.

1.3.17 Explore incorporation of treatment pathways into eHealth initiatives to support and improve patient treatment and referral.

Mental Health:

1.3.18 **Employment of a full time ATAPS project officer:** Two full time staff are now employed in order to develop linkages with GP's and AHP's to allow for effective communication and treatment of patients referred into the ATAPS program. This development work will continue in order to improve patient's journeys and continuity of care within the

ATAPS program.

1.3.19 **Application for a Aboriginal Mental Health Traineeship:** An application has been made for funding for a liaison position to develop the care of aboriginal patients within our medicare local, this would improve the coordinated care for our patients and link in with existing local community services.

1.3.20 **Expansion of the ATAPS model:** Development and research is underway to expand the existing ATAPS model into a hybrid program to allow for better access of services for patients as well as bridging existing identified gaps within the ATAPS program.

1.3.21 **LHD Mental Health Planning:** A planning committee has been developed consisting of clinical leads and mental health program co-ordinators from both our local health district and the Western Sydney Medicare local to plan and explore linking service and patient models with Western Sydney. Initially agreeable outcomes will be identified and plans will then be developed to address the needs outlined.

1.4 Integrating General Practice / Primary Health Care Training with Service Delivery and Coordination

1.4.1 The PGPP Program has increased in 2012 with placements being filledfrom Blacktown Hospital, Nepean Hospital and Westmead Hospital. A total of 24 JMOs will experience training in the General Practice setting this year as a result of the commitment to the PGPP program in our region.

1.4.2 First Wave Scholarship Program – following positive feedback from the Medical Students undertaking these scholarships over the past three years we will continue to support the First Wave Scholarship program into the future presenting the opportunity for Medical Students to trail General Practice prior to finalising career choices. We will see a 50% growth in 2012 with 15 students being offered scholarships an increase from 10 in 2011.

1.4.3 Through the Education Integration Project, a partnership between WentWest, the University of Sydney and the University of Western Sydney, four geographically based cluster areas have been developed throughout our region to foster vertical integration of teaching for Medical Students, GP Registrars and Prevocational Doctors undertaking GP Rotations through PGPPP. It is planned that the cluster areas will look at multidisciplinary teaching as well as research within General Practice.

1.4.4 The Western Sydney Primary Care Teaching Network has successfully continued Student Nurse placements within the region. A small number of Dental Students have also been placed.

1.4.5 Collaboration continues with the University of Sydney, the University of Western Sydney and WentWest growing and supporting our practices who support all levels of learner in the General Practice environment. This includes GP Registrars, Junior Doctors as well as Nursing, Dental & Physiotherapy students.

1.4.6 We are considering opportunities for GP Registrars to undertake Extended Skills Posts which may include programs linked to core WSML activity. Extended skills posts in Refugee Health, Justice Health and Psychiatry focus on some of the identified needs of the population within Western Sydney and offer the opportunity for Registrars to develop their knowledge and skills in these disciplines.

Strategic Objective 2. Provide support to clinicians and service providers to improve patient care

2.1 Community Programmes

Identification of Aboriginal and Torres Strait Islander population: To increase identification in General Practice WentWest will:

2.1.1 Provide practices with culturally appropriate promotional resources which encourage local ATSI patients to identify

2.1.2 Provide group-based and personalized training to GPs and practice staff on the relevance of identification and how to achieve this in a culturally sensitive manner. This includes the distribution of identification factsheets which offer frontline practice staff further insight into the importance of identification and how to handle patient queries resulting from increased promotion.

2.1.3 Implementation of care pathways from general practice into local service providers including Western Sydney Local Health District and Aboriginal Medical Service Western Sydney and programs such as HealthOne, Severe Chronic Disease Management etc to support GPs with the management of patients who identify.

2.1.4 Increase the number of practices registered for the PIP Indigenous health Incentive

2.1.5 Provide access to localised Cultural Awareness training for GPs, Nurses, practice staff and other health providers to gain a better understanding of the history and issues that have affected Aboriginal and Torres Strait Islander people.

Support GPs for effective Diabetes Management: WentWest will work with GPs, PNs and practices to promote and achieve accurate Diabetes data recording by:

2.1.6 WSML will enhance care pathways through the HealthOne initiative, severe chronic disease management initiative, Close the Gap and SCDM initiatives to coordinate care and manage patients with diabetes

2.1.7 Provide a Diabetes Support Clinic to for GPs, PNs and practices to refer their Aboriginal and Torres Strait Islander patient through WentWest SHAPE program. Clinic will also allow Aboriginal and Torres Strait Islander patients who are engaged in the WSML Close the Gap to be referred and access the SHAPE program.

2.1.8 Assist GPs and practices in doing Aboriginal Health Assessments to identify early detection of Diabetes amongst Aboriginal and Torres Strait Islander people.

2.2 Programme Integration – see Objectives 1 & 3

Practice Support:

Implement a new model of practice support across general practice and allied health that employs key account management principles and a need-based approach to segmenting clinicians and their practices to enable delivery of tailored and relevant clinical and business support including:

Education and Training

2.2.1 Provide a series education and training opportunities to Primary Health Care Professionals. Events will include topics specific to professional roles as well as multidisciplinary topics.

2.2.2 Support existing local GP associations and establish local GP networking groups in remaining LGAs to identify local health care needs to address education needs by hosting Local CPD events and partnering with Local Community Partnership activities to address these needs.

2.2.3 Sponsor and host educational opportunities for Primary Health Care Professionals such as Practice Nurses and Allied Health on preventative,

chronic and acute presentations.

2.2.4 Sponsor and host business training opportunities for primary health care support staff such as Practice Managers and Receptionists.

2.2.5 Expand on existing education and training opportunities hosted by the WentWest Regional Training Provider services such as offering online CPD opportunities to GPs who are not trainers.

2.2.6 Build on existing relationships with the RTP to establish a robust education and support process supporting medical students right through to GP Fellowship.

2.2.7 Build on the existing practice support model for general practice to establish a support model for Allied Health Care Professionals that will support service provision to improve patient care.

Best Practice

2.2.8 Continue to promote and support Accreditation Status to general practices.

2.2.9 Recruit and support general practices to participate in existing quality improvement programs such as WentWest's Quality Practice Program and programs offered by other health care organizations. WentWest will purchase and support data extraction tools for all general practices our region in order to utilize service level population planning to feed into the population health profile collected by WentWest to be used as evidence based data in service planning.

2.2.10 Provide IMIT guidelines and data management support to GPs and AHP to aid computerization, electronic records, recalls and reminders and the uptake of the **PCEHR**.

Information and Resource Distribution

2.2.11 Collect and distribute information, guidelines and resources relevant to General Practice and Allied Health Care Professionals on clinical and business needs via our website, elists, events, practice visits, fax and mail outs.

2.2.12 Utilise communication channels with the PCEHR program to collect and distribute relevant clinical information.

2.2.13 Support general practitioners and allied care professionals implement systems to increase breast screening, cervical screening and bowel screening through programs and educational opportunities.

Business Systems

2.2.14 Maintain GP business system support by assisting general practices increase capacity, access to patients and utilization of MBS item numbers through support services on improving business systems such as communication, appointments and clinics.

2.2.15 Establish similar business support services for Allied Health Professionals.

2.2.16 Support business systems for GPs and AHPs by providing basic training opportunities around team work, infection control, confidentiality, risk management,

MBS item numbers and clinical and business software usage

2.2.17 Provide and support GPs and AHP implement quality improvement strategies through the use of data extraction tools and PDSA (Plan, Do, Study, Act) cycles.

2.2.18 Provide financial modeling and business development support tools and support to GPs and AHP through events and resource provision.

2.2.19 Provide IMIT guidelines and support to GPs and AHP to aid the uptake of the PCEHR.

Integration

See strategic objective 1

Feedback on Performance

2.2.20 Distribute population health data to GPs and AHP

2.2.21 Recruit and support general practices to participate in existing quality improvement programs such as WentWest's Quality Practice Program and programs offered by other health care organizations. WentWest will support data extraction tools for all general practices in our region in order to utilize service level population planning to feed into the population health profile collected by WentWest to be used as evidence based data in service planning.

2.2.22 Facilitate GP and patient participation in the Antenatal Shared Care Program.

Workforce

2.2.23 Identify workforce gaps

2.2.24 Facilitate GP, PN, PM, AHP placement in general practices by keeping listings of general practices vacancies and providing their contact details to be distributed on request and by other electronic means

2.2.25 Provide recruitment and induction support general practice to increase the numbers of practices nurses joining general practice

2.2.26 Develop and provide a Medicare Local induction program for new Primary Health Care Professionals. The induction will include flexible delivery of basic modules of informal presentations on the services of the Medicare Local.

2.2.27 Assist general practitioners apply for Area or Need and District of Workforce shortage

2.2.28 Assist general practices apply for Federal Government Infrastructure Grants

2.2.29 Work with local universities and the Western Sydney Primary Care Teaching Network to place student nurses in general practice

2.2.30 Build on our existing education networks to place medical students, allied health professionals and business students in general practice

2.2.31 Identify workforce gaps in community nursing and residential aged care facilities and assist placement by promoting vacancies.

eHealth

2.2.32 Continue to progress the IM/IT Reference Group and expand scope to include a group or advisors with a special interest in the PCEHR and the national eHealth strategy.

2.2.33 Continue to provide practices with training workshops to improve their management of clinical information and efficiency in both clinical and billing management systems.

Mental Health:

2.2.34 ATAPS Provider training: A training plan is being developed to allow for increased professional development for existing ATAPS providers. We have already provided access and registration for training in the area of suicide prevention and will in the future be offering training on providing a culturally appropriate service as well as child and adolescent service provision training.

2.2.35 GP Education: A level 1 mental health skills training program to be run for GP's to allow them to develop and increase their confidence in working with their mental health patients.

2.2.36 Continued regular educational visits held with GP's, practices and services on accessing mental health programs and services within the medicare local catchment.

NPS

NPS facilitators will continue to build networks and support GPs across Western Sydney. The continuing focus will be:

2.2.37 Quality Use of Medicines focusing on agreed topics

2.2.38 Continue to provide independent, evidence based drug information to GPs through the NPS contract

2.2.39 Plan, schedule and deliver at least two therapeutic programs each year using 1:1 Educational visiting or Small Group Meetings.

2.2.40 Build relationships and support growth of active medical practices

2.2.41 Continue to provide support for general practitioners to focus on better patient outcomes

2.2.42 Follow up with general practitioners to provide ongoing support and services based on their practice and patient needs

2.2.43 Build to engage pharmacists, practice nurses and other community health professionals in locally delivered NPS activities.

Strategic Objective 3. Identification of the health needs of local areas and development of locally focused and responsive services

3.1 Community Programmes
Progress the Community and Consumer forum which seeks to:

3.1.1 Communicate initiatives undertaken by the Medicare Local which address local health needs and service gaps;

3.1.2 Obtain feedback on the Medicare Local's performance in meeting public expectations and its strategic objectives;

3.1.3 Strengthen the Medicare Local's relationship across all sectors which impact on the local primary health care system (sectors include: Education; Family & Early Childhood; Police & Law Enforcement; Refugee and Multicultural Affairs; Welfare; Aboriginal Affairs and Housing);

3.2 Program Integration

3.2.1 Population Health Needs Analysis and Priority Planning - Deloittes will be contracted to develop a Population Health Needs Analysis capturing all available secondary data at an LGA level and where available SLA level of direct health statistics and social determinants of health. This will be complemented by the stakeholder and community consultation. Additional data will be provided by the Local Health District in areas of preventative health and acute presentations. The Analysis will provide the basis for the Priority Planning activities to be undertaken with the LHD and key stakeholders. A Population Health Reference Committee will be developed to guide and provide feedback on the data collected and it's relevance to the health issues of the community. The committee will consist of representatives from the LHD, ML, State Health, Local Government, primary health providers and consumers. Draft areas for investigation and research are as follows:

- *Epidemiological data to understand trends and population health needs going forward, particular relating to chronic disease (and will need to include communicable disease - for example we have the highest rates of Hepatitis B in all of NSW)*
- *Services provision and workforce availability/location currently, and bottom-up responsive solutions to issues identified in data analysis and from existing local knowledge about gaps*
- *Stakeholder consultation – workshops and interviews with local area coordinators and others to develop an appropriate Population Health Plan (a lot of information and mapping has already occurred in WentWest)*
- *The role of integration/coordination, community engagement, and governance in the Plan (data to inform strategies that improve continuity of care among general practice, acute and sub-acute care – opportunities to utilise eHealth and align with our PCEHR program)*
- *How to plan and align resources with local needs (financial plan)*
- *If possible- service utilisation (not necessarily via MBS billings) and appropriateness of utilisation (there is evidence of significant issues with health care card holders and pension card holders misusing ambulance and ED services)*
- *Which patient demographics are utilising which services to inform who are the hard to reach groups (CALD and Aboriginal/Torres Strait Islander communities, refugee groups and recent immigrants)*
- *Opportunities to research the inconsistencies between mortality rates and morbidity rates.*
- *Primary Health Care workforce distribution and gaps (GPs, allied health)*

3.2.2 The LCPs will be utilized to provide an environmental audit of local health care needs and available services in Western Sydney at an LGA level. This will provide ongoing feedback to the ML for future planning and capacity building. As part of the Level 2 stakeholder engagement, health need information will be collected at the consumer and community group level to provide ongoing data to support service planning and identify workforce needs.

3.2.3 The LHD-ML Partnership will play a key role in identifying joint health care priorities reflecting the needs of the communities which they service. Working Groups in each of the 10 priority areas identified to date will be developed to provide information within these areas in regards to services and service gaps as well as identifying opportunities for improved coordination of primary and secondary service delivery.

3.3 Practice Support:

Practice Profiling

3.3.1 Collect service profiles data from general practice and allied health care professional organizations and individuals

3.3.2 Complete a needs assessment for general practitioners, practice nurses, practice managers and allied health care professionals

3.3.3 Population Planning and Service on a practice level

3.3.4 Installation, support and use of the PENCAT tool to assist general practice identify patient groups and develop strategies to meet their needs through the QPP program.

3.3.5 Utilise information from LCP work to feedback back to GPs and AHP

3.3.6 Feedback information to AHPs and develop partnerships to engage and mobilize AHPs to address patient needs using evidence based data

3.3.7 Utilise existing support services and resources developed by the work from the Divisions of General Practice to provide tailored practice support around the areas of mens and womens health, indigenous health, immunisation, mental health, prevention and health promotion, antenatal shared care, chronic disease management etc.

3.3.8 Implement a key account management practice support model to provide tailored services to general practices

3.3.9 Build on existing support services and resources developed by the work from the Divisions of General Practice to provide support around the same areas for AHP.

3.3.10

3.3.11 Liaise and collaborate on projects with existing local GP associations such as Mount Druitt Medical Practitioners Association, Blacktown Medical Practitioners Association, Indian Medical Association, Australian Arabic Medical Association and the Filippino Medical Association to meet patient needs through community initiatives.

3.3.12 Build partnerships with Local AHP associations and AHP professional bodies to provide address local patient needs through service provision and program participation.

3.3.13 Strengthen partnerships and increase GP participation in LHD initiatives

3.3.14 Build partnerships and increase participation of AHP in LHD initiatives

3.3.15 Continue to collaborate with local council and community organizations to address increase childhood immunisation rates.

3.3.16 Promote health initiatives to local community through community health promotion events and talks.

3.3.17 Facilitate work place and community health screening initiatives

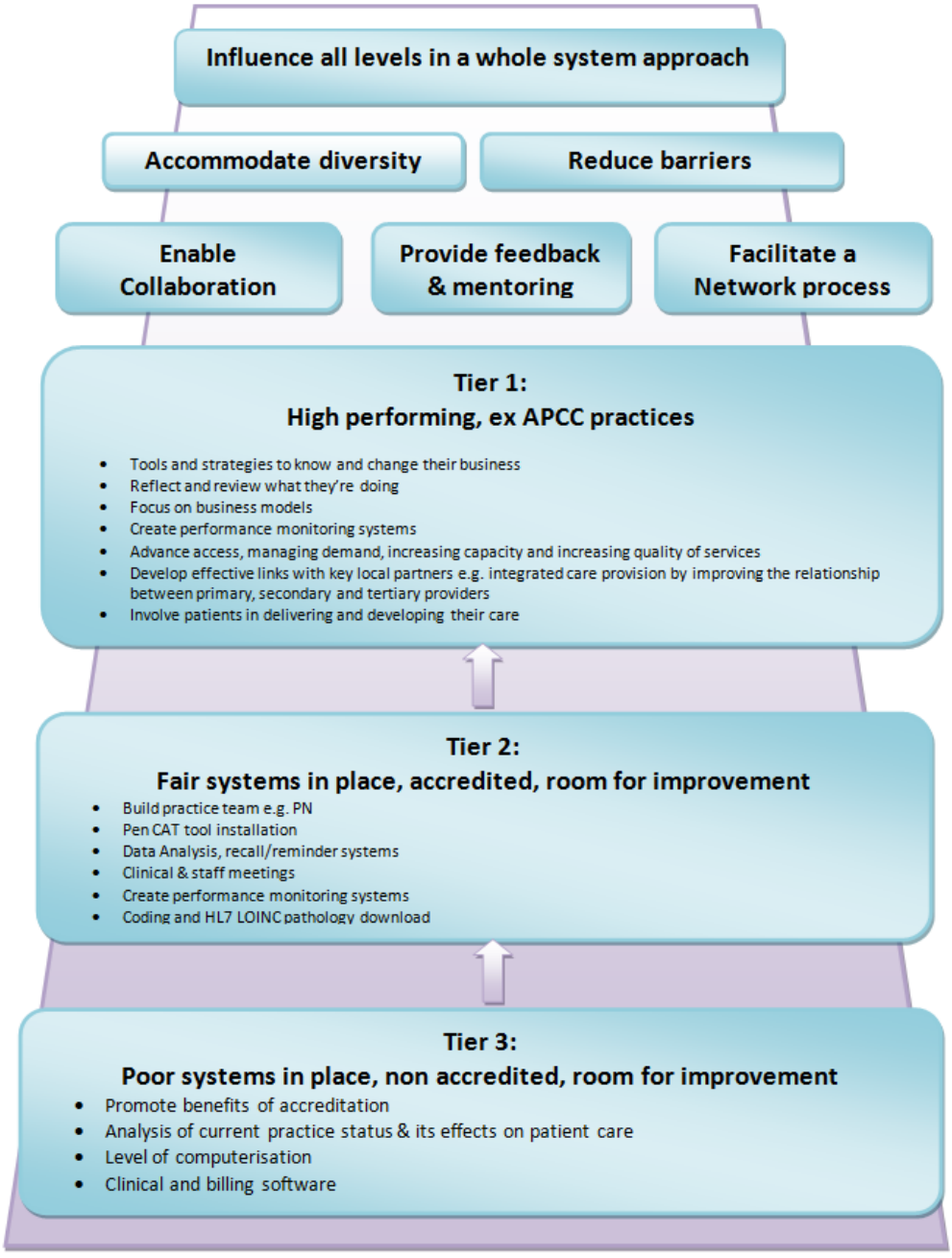
Quality Improvement

3.3.18 QI framework will create a systematic and focused way of using a whole system approach by which several programs across the organisation can synergistically contribute to accommodate and cater to the diversity of current health services by reducing barriers to care and collaboration amongst primary, secondary and tertiary health service providers.

3.3.19 The system seeks to provide the infrastructure necessary for continuous feedback and mentoring whilst facilitating networking processes amongst health service providers.

3.3.20 The first step to approach health service capacity will be to identify the issue. WentWest will assist health services with defining what capacity they require. A template adapted from the Australian Primary Care Collaboratives (APCC) program will be used to calculate capacity and demand, The template will provide the health service with the information necessary to devise solutions for their practice systems.

3.3.21 WentWest will continue to use the Pen CAT Tool as part of the Quality Practice Program to capture de-identified aggregated data in order to produce analysis reports depicting population health status by LGA and feeding these into population health profiles facilitating and solidly informing health service re-distribution decision making. The following model will support data collection and data analysis activities by engaging health services at their appropriate level of readiness and ability:


Influence all levels in a whole system approach
Accommodate diversity
Reduce barriers
Enable Collaboration
Provide feedback & mentoring
Facilitate a Network process
Tier 1:
High performing, ex APCC practices
Tools and strategies to know and change their business
Reflect and review what they're doing
Focus on business models
Create performance monitoring systems
Advance access, managing demand, increasing capacity and increasing quality of services
Develop effective links with key local partners e.g. integrated care provision by improving the relationship between primary, secondary and tertiary providers
Involve patients in delivering and developing their care
Tier 2:
Fair systems in place, accredited, room for improvement
Build practice team e.g. PN
Pen CAT tool installation
Data Analysis, recall/reminder systems
Clinical & staff meetings
Create performance monitoring systems
Coding and HL7 LOINC pathology download
Tier 3:
Poor systems in place, non accredited, room for improvement
Promote benefits of accreditation
Analysis of current practice status & its effects on patient care
Level of computerisation
Clinical and billing software

Mental Health

3.3.22 **Service Mapping:**

Recruit a program manager to map local services specifically in child and adolescent mental health as well as existing pathways and patient journeys. A process will then be undertaken liaising with existing providers to identify the gaps which will then drive the ATAPS child and adolescent model.

3.3.23 **Partners in recovery program:** A collaborative application is being developed for the partners in recovery program to be run within Western

Sydney. The process of developing a consortium for this program will involve identifying the areas of need for patients in this program who are managing acute and long term mental illness. As part of this process the patient pathways will be examined to ensure that a patient model of care is developed to result in the best outcomes for all services involved in the consortium application.

Strategic Objective 4. Facilitation of the implementation and successful performance of primary health care initiatives and programs

4.1 **Community Programmes**

Expand and enhance the Sessions for Health And Physical Exercise (SHAPE) program

4.1.1 Establish a schedule of SHAPE programs for each LCP which addresses local needs in relation to chronic disease prevention and health promotion.

4.1.2 Work in collaboration with local health and community organisations to provide tailored SHAPE programs to high risk population groups. This includes ATSI and CALD communities as well as mental health clients, mother's groups and overweight and obese children and their families.

4.1.3 Work with local health and community organisations in collaboration with the LCP team to identify opportunities to present at health promotion events in order to increase community health literacy and awareness of services available.

4.1.4 Identify and attend appropriate community open days and events which promote healthy living.

4.1.5 Pilot e-communication channels which provide existing/outgoing SHAPE participants with ongoing advice and resources to stay engaged.

4.1.6 Implement a "Heroes" initiative to encourage past participants to act as program ambassadors within their local community.

4.1.7 Enhance direct marketing to the community as a means of gaining motivated, committed participants.

4.1.8 Maintain the development of media campaigns to align with broader public health awareness campaigns.

4.1.9 Expand SHAPE services to include community group fitness programs as an option for participants exiting other branches of SHAPE.

4.1.10 Expand the SHAPE community group fitness program as an affordable, local group exercise option.

4.2 Programme Integration

4.2.1 HealthOne - Although HealthOne has primarily focused on Child and Family Health as well as Chronic, Aged and Complex Care, the partnership will facilitate expansion on clinical service delivery to meet the needs of local populations across Western Sydney eg. Women's Health Clinic, Refugee Health Clinic, Wound Care Management, Youth Health Clinic, Paediatric Specialist Services and private Allied Health providers. These services are delivered within a 'hub and spoke' model where appropriate as well as utilizing virtual care coordination models to ensure the services meet the needs of the local community.

4.2.2 Local Community Partnerships have identified and will continue to respond to local health needs within each LGA to facilitate the implementation of primary health care initiatives including:

- Multicultural Oral Health targeting the Pakistani community in the Blacktown LGA to improve oral health awareness, service access, links between oral and physical health and service provider engagement.
- Cervical Screening Program addresses the needs of the CALD and At Risk communities within Western Sydney to improve cervical screening awareness, utilization of services and recall/reminders to GP patients.
- Women's Wellness Program targeting women from CALD backgrounds within the Auburn LGA to improve physical activity, nutrition and Child and Family Health in a holistic context.
- Hepatitis B Program will work with GPs and other health service providers to improve identification and treatment for patients with Hepatitis B from CALD (Asian) communities within Western Sydney.
- SHAPE will work with Holroyd Council to provide programs on physical activity, nutrition and preventative health for identified vulnerable communities within the LGA.
- Hospital In The Home project in conjunction with Blacktown Mt Druitt Hospital developing a coordinated model of care for patients who present to the Emergency Department with a primary diagnosis of cellulits. The development of a clinical pathway beginning in the community will facilitate better identification and management of cellulitis to prevent avoidable hospital presentations and decrease Length of Stay.

4.2.3 Connecting Care - Will continue to expand care coordination service within Western Sydney according to local population health care needs. Care coordination services are expected to increase their reach by more than

200 patients in 2012-13.

4.3 Business Programmes

Practice Support

Promote and Recruit

4.3.1 Identify general practices and AHP to participate in primary health care initiatives and programs including CTG, NPS, ATAPS, PCEHR and After Hours

4.3.2 Promote and recruit GP and AHP to participate in primary health care initiatives and programs including CTG, NPS, ATAPS, PCEHR and After Hours

4.3.3 Support GPs and AHP with basic business systems and knowledge to enable program participation.

4.3.4 Provision of staff training on business related topics such as finance management and risk management

4.3.5 Collection and distribution of information, guidelines and resource around business requirements and needs.

Quality Improvement

4.3.6 The focus on prevention and early intervention will be maintained through clinical performance indicators provision and management. Our experience has shown that as soon as a clinician is aware of their performance in numerical terms they focus is on improving that status through interventions readily available. Monitoring performance in a positive way has triggered shifts in clinician behavior and led to better service delivery.

4.3.7 The QI unit will identify evidence-based strategies to improve health outcomes for each local area. Appropriate de-identified aggregated data will be collected and analysed to produce reports on up-to-date epidemiology status and MBS item utilization.

4.3.8 Service delivery improvement as well as clinical efficiency and efficacy will be measured and monitored via the following key indicators:

- Effectiveness – Safety and Quality will be measured via clinical indicators such as the number of patients on the Diabetes register, % of Diabetes patients and their HbA1c status in the previous 12 months, Cholesterol levels < 4mmo/l, Blood Pressure < 130/80 mmHg, Aspirin management for over 55 y.o patients, ACR testing, % of annual cycle of care plans completed, number of patients with a written asthma plan, spirometry testing, screening rates for breast, cervical and bowel cancer.

4.3.9 Health service providers participating in QI initiatives will be able to

quarterly monitor the impact of their interventions and compare their performance against a local area and national benchmark.

Mental Health

4.3.10 ATAPS Suicide Prevention Model: An integrated care model is being developed for the service delivery of the ATAPS suicide prevention program. An agreement has been made to provide an in-house service within the Blacktown Mental Health Service to support their current program and allow for patients to access wrap around services for their treatment. The program will be jointly managed and promoted with the medicare local and the local health district.

Strategic Objective 5. Be efficient and accountable with strong governance and effective management

WentWest established a representative and fully recruited skills-based Board in January 2012(details contained in this Plan) which is operating effectively and with the current areas of focus:

Working with the following system operating principles:

- Improve health, wellness and capacity through community engaged, cross sector PHC action - reflecting existing World Health Organisation (WHO principles).
- Utilise Local Government Areas as the major functional sub-unit.
- Build *bottom up* on what already exist.
- Build partnerships and collaboration at every level.
- Develop new integrated patient care and service models.
- Integrate teaching and research into health service planning and delivery.
- Build quality teaching networks through *HealthOne* community hubs, lead teaching practices, AMSs, practice and service clusters.

All Board sub committees are established and operational and the Clinical Governance sub committee is currently reviewing an audit conducted by Quros to determine ongoing areas of focus and how we will further enhance our clinical governance capability. Outcomes of this review will be incorporated into our

planned activities for the coming 12 months

The work of the sub-committee will be informed by both the clinical governance framework developed by Quros for Medicare Locals and the framework contained in the paper,

Australian Institute of Company Directors (2011). The Board's Role in Clinical Governance

Within the broader governance framework present on page 9, the effective integration and delineation of Board and Senior Management is clearly established and functioning effectively with collective priority areas of focus on:

- Risk management
- Clinical Governance

In terms of mechanisms to integrate information relating to clinical priorities and governance, the reader is referred to the WSML/ WSLHD partnership details outlined earlier in the Plan.

2 Medicare Local After Hours Program

2.1 Key Activities

The aim of the Australian Government's reforms in after hours is to provide all Australians, regardless of where they live, with accessible and effective after hours primary health care services.

In order to achieve this, you must work towards achieving the following Medicare Local After Hours (MLAH) Program objectives:

- ensuring that local after hours primary health care services are well planned, coordinated and appropriate to community needs;
- ensuring primary health care services are accessible when needed in both the sociable and unsociable after hours periods, including for disadvantaged groups such as the residents of aged-care facilities, the homeless, the house-bound aged and palliative care patients;
- assist with directing patients to the most appropriate point of care for their condition; and
- supporting GPs and health professionals in the provision of after hours primary health care for patients.

Instructions

For each MLAH Program objective you are required to state:

- specific activities that you will undertake to achieve the objective; and
- indictors that will allow you to measure progress towards achieving the objective.

Each discrete activity should be listed as its own uniquely numbered dot point (Eg 1.1, 1.2, 1.3). The Medicare Local will then report against each of these dot points as achieved/not achieved in it's 6 and 12 month reports. Please list your planned activities only once, against only one Strategic Objective even if they align with more than one Strategic Objective.

Please ensure that you have provided sufficient detail about your organisation's planned activities to clearly indicate how you intend to go about the activity.

For example, this description of an activity is too general: "Pro-actively engage with practitioners across the spectrum of primary health care provision". A more meaningful description is: "Hold a series of workshops with aged care facilities to discuss integration of patient care with GPs, allied health and hospitals."

Rationale

Setting out the Medicare Local activities for the financial year provides the mechanism for the Medicare Local and the Department to agree how the Medicare Local plans to address the program objectives and expend the program funds over the coming financial year.

How the Department will assess this section

The Department will assess the appropriateness of your planned activities as to:

- whether they will enable the Medicare Local to meet the relevant Program Objective; and
- whether they are consistent with '*Medicare Locals – Guidelines for after hours primary care responsibilities until 30 June 2013*' and the subsequent Medicare Local After Hours Program Schedule under the Medicare Local Deed for Funding).

Objective 1. Ensure that local after hours primary health care services are well planned, coordinated and appropriate to community needs.

1.1 Build on the After Hours Needs Assessment by continuing consultation and data analysis around after hours care to work towards the development of the Stage Two Plan.

1.2 Hold quarterly after hours healthcare planning forums bringing together representatives of hospitals, general practice, NSW ambulance, aged care and other after hours services to improve provision of care based on identified local health needs.

1.3 ML to take on an after hours coordination role to work towards improving understanding, collaboration, linkages and referrals between after hours primary care services, including GPs and EDs, aged care and deputising services etc. In particular, options for improved linkages between aged care facilities, the *GP helpline* and after hours deputising services will be explored by the WSML in the 2012-2013 period.

Objective 2. Ensure primary health care services are accessible when needed in both the sociable and unsociable after hours periods, including for disadvantaged groups such as the residents of aged-care facilities, the homeless, the house-bound aged and palliative care patients.

2.1 Encourage and subsidise registration of Mt Druitt GPs with deputising services to improve accessibility of after hours care, especially for patients who lack access to transport, and for all patients during the unsociable hours.
2.2 Targeted funding to be provided to general practices and deputising services to address identified service gaps in after hours healthcare (Proposed activity under Stage One Plan)
2.3 Applications for funding grants to be assessed against After Hours Guiding Principles to ensure funded after hours services meet accessibility and effectiveness requirements (Proposed activity under Stage One Plan).

Objective 3. Assist with directing patients to the most appropriate point of care for their condition.

3.1 Promote the GP Helpline and NHSD in general practice and other community services across Western Sydney to improve access to after hours primary health care services and to promote appropriate utilisation of services.
3.2 Develop and distribute of local after hours service directories (Proposed activity under Stage One Plan)
3.3 Online awareness campaign promoting service directories and linking to the NHSD and *GP helpline* to ensure easily accessible, up to date information (Proposed activity under Stage One Plan)
3.4 Continue community education events in Mt Druitt to improve awareness and understanding of after hours primary healthcare and to provide basic health promotion including around the importance of having a regular GP.
3.5 Hold a series of education sessions across the region, providing information on after hours healthcare, targeted towards groups with poor health literacy or awareness of after hours services. (Proposed activity under Stage One Plan)
3.6 Present after hours healthcare information at a series of inter-agency meetings across the region to facilitate a greater distribution of information. (Proposed activity under Stage One Plan)
3.7 Maintain up-to-date service information for directories and other promotion through ongoing liaison with service providers.

Objective 4. Support GPs and health professionals in the provision of after hours primary health care for patients.

4.1 Support for practices in Mt Druitt as part of the known gaps implementation, to improve or expand existing after hours services, or set up new after hours services. This support is integrated with overall practice support in the areas of accreditation, quality improvement, recruitment and training.

4.2 Security and safety training and resources to be provided to after hours service providers in Mt Druitt.

4.3 Provide a primary contact within the WSML for service providers' queries regarding after hours healthcare issues.